Achilles Foot & Ankle

MEDICAL HISTORY

Reason for Today's Visit

Patient's Name (Last, First, M.I.): | Date:

Please describe current problem:

Which lower extremity: ❑Left ❑Right | How long has this problem troubled you:

Have you undergone previous treatment for this problem: ❑Yes ❑No If yes, please describe:

Is your problem a result of injury: ❑Yes ❑No If yes, date of injury: | Did injury occur while at work: ❑Yes ❑No

Medications (prescription and nonprescription medications)

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

Allergies

Please indicate: ❑No known allergies ❑Yes, please list below (medication, food, materials etc.)

Medical History (please check all that apply)

	Yes	No		Yes	No
Arthritis/Bone-Joint Problems	❑	❑	Eye Problems	❑	❑
Anemia	❑	❑	Gout	❑	❑
Asthma/Breathing/Lung Problems	❑	❑	Gynecological Problems (Females)	❑	❑
Back Problems	❑	❑	Head and Neck Problems	❑	❑
Bleeding Problems	❑	❑	Heart Attack Date _____	❑	❑
Blood or Blood Product Transfusion	❑	❑	Hepatitis/Jaundice/Liver Disease	❑	❑
Blood Clots	❑	❑	High Blood Pressure	❑	❑
Cancer	❑	❑	High Cholesterol	❑	❑
Chemotherapy	❑	❑	Injury/Trauma Kidney Problems	❑	❑
Chest Pain/Heart Problems	❑	❑	Kidney Dialysis (Circle Days) M T W T F S S	❑	❑
Circulatory Problems	❑	❑	Lower Extremity Wounds	❑	❑
Diabetes	❑	❑	Lyme Disease	❑	❑
Dropfoot	❑	❑	Neuromuscular Disease	❑	❑
Ear/Nose/Throat Problems	❑	❑			

Medical History (Please check all that apply)

	Yes	No		Yes	No
Numbness or Weakness	❑	❑	Seizures/Epilepsy	❑	❑
Other Serious Illnesses	❑	❑	Sickle Cell Disease or Trait	❑	❑
Pacemaker	❑	❑	Skin Problems	❑	❑
Polio	❑	❑	Stroke Date: _____	❑	❑
Positive Culture for MRSA/VRE	❑	❑	Stomach/Intestinal Problems/Ulcers	❑	❑
Positive Test for HIV	❑	❑	Tetanus Immunization Date:_____	❑	❑
Previous Diabetic Foot Wounds	❑	❑	Thyroid Problems	❑	❑
Prostate Problems (Males)	❑	❑	Tuberculosis	❑	❑
Psychiatric/Emotional Disorder	❑	❑	Urinary Tract Problems	❑	❑
Recent Weight Gain/Loss	❑	❑	Venereal Disease	❑	❑

Family History

Father: Living_____ Deceased_____ Mother: Living_____ Deceased_____ Siblings: indicate # of siblings_____

Does or did anyone in your immediate family have any of the previously mentioned medical problems: ❑Yes ❑No

If yes, please describe:

Surgical History

Previous foot or ankle surgery: ❑Yes ❑No If yes, please describe: ❑Right ❑Left

Previous surgery other than foot or ankle: ❑Yes ❑No If yes, please describe:

Have you ever had any anesthetic agents: ❑Yes ❑No If yes, please indicate: ____General ____Spinal ____Epidural

____Sedation ____Local ____Regional | Please describe any complications:

Do you have any internal metal, vascular or other implants (pins, grafts, screws, plates, clips, joints, etc.): ❑Yes ❑No

If yes, please describe:

Personal History

Do you smoke: ❑Yes ❑No If yes, how much:

Do you drink alcohol: ❑Yes ❑No If yes, how often:

Are you pregnant or breast feeding (females): ❑Yes ❑No If no, are you trying to become pregnant: ❑Yes ❑No

Do you participate in physical fitness activities: ❑Yes ❑No If yes, please describe:

Are you: ❑Right handed ❑Left handed ❑Both | Weight: _____ | Height: _____

Do you use: ____Cane ____Walker ____Brace ____Crutches ____Wheelchair ____Prosthesis

Shoe size:_____ Shoe width:_____ What type of shoes do you wear: _____

If there is additional information that you think the doctor should know, please describe below.